FUNCTIONAL ELIGIBILITY SCREEN FOR CHILDREN'S LONG - TERM SUPPORT PROGRAMS

Individual Information

Screen Information		
Screener's Name:		Screening Agency:
Referral Date (mm/dd/yyyy): / /	Screen Begin Date (mm/dd/yyyy): / /	Screen Type (Check only one box): ☐ 01 Initial Screen ☐ 02 Annual Screen ☐ 03 Screen due to change in condition or situation (or by request)

Referral Source (Check only one option.)

- ☐ Parent(s)
- ☐ Other Relative
- ☐ Guardian (Non-Relative)
- ☐ Self
- ☐ Audiologist
- ☐ Birth-to-3 Program
- ☐ Child Care Provider
- ☐ Child Protective Services
- ☐ Children with Special Health Care Needs
- ☐ Family Support Program
- ☐ Foster Care
- ☐ Hospital, Clinic
- ☐ Out-of-Home Setting
- ☐ Physician
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Public Health
- ☐ School
- ☐ Social Worker
- ☐ Special Needs Adoption
- ☐ State Center
- ☐ Therapist - Physical, Occupational or Speech Language Pathologist
- ☐ Other - Please specify:

Child's Basic Information		
First Name:	Middle Name:	Last Name:
Social Security Number (xxx-xx-xxxx): – –	Date of Birth (mm/dd/yyyy): / /	Gender: ☐ Male ☐ Female
County / Tribe of Residence: May enter a 2nd if dual residency. /	County of Responsibility: May enter a 2nd if shared responsibility. /	

U.S. Citizenship (Check only one option.)

- ☐ Adoption Records
- ☐ Baptismal Records
- ☐ Birth Certificate
- ☐ Citizenship Papers
- ☐ Documented with SSN
- ☐ Hospital Birth Records
- ☐ Passport
- ☐ SSA Document
- ☐ SSA or SSI Records or Checks
- ☐ State Department Records
- ☐ Social Security Card
- ☐ Alien Registration Number - Please specify:
- ☐ Other - Please specify:

Race/Ethnicity (Optional) (Check only one option.)	
☐ American Indian or Alaskan Native	☐ Caucasian (white/non-Hispanic)
☐ Asian or Pacific Islander	☐ Multi-racial
☐ Black	☐ Hispanic
☐ Other - Please specify:	

If an interpreter is required, check language below (Check only one option.)	
☐ American Sign Language	☐ Russian
☐ Hmong	☐ Spanish
☐ A Native American Language	☐ Vietnamese
☐ Other - Please specify:	

Contact Information

Primary Parent (This is the parent who will receive correspondence on the child's behalf.)		
First Name:	Middle Initial:	Last Name:
Address:		
City:	State:	Zip:
Home Phone (xxx) xxx-xxxx:	Work Phone (xxx) xxx-xxxx:	Cell Phone (xxx) xxx-xxxx:
When is the best time to contact the parent:		

Additional Parent in Primary Household			
First Name:	Middle Initial:	Last Name:	Work Phone (xxx) xxx-xxxx:
When is the best time to contact the parent:			

Secondary Parent (If Joint Custody)		
First Name:	Middle Initial:	Last Name:
Address:		
City:	State:	Zip:
Home Phone (xxx) xxx-xxxx:	Work Phone (xxx) xxx-xxxx:	Cell Phone (xxx) xxx-xxxx:
When is the best time to contact the parent:		

Court-Appointed "Guardian Of Person"		
First Name:	Middle Initial:	Last Name:
Address:	Phone (xxx) xxx-xxxx:	
City:	State:	Zip:
When is the best time to contact the parent and/or comments:		

Child's Medical Insurance

Insurance Information (check all that apply and clearly write numbers)			
☐ Medicare	Policy Number:		
	☐ Part A ☐ Part B ☐ Medicare Managed Care		
☐ Medicaid	Policy Number:		
☐ Railroad Retirement	Policy Number:		
☐ Private Insurance # 1(includes employer-sponsored [job benefit] insurance)	Company Name:	Policy Number:	Individual Number:
☐ Private Insurance # 2 (includes employer-sponsored [job benefit] insurance)	Company Name:	Policy Number:	Individual Number:
☐ Other Insurance - Please specify:			
☐ No medical insurance at this time			

Primary Care Physician

- ☐ Applicant has a physician that meets most primary medical needs.

If applicant has a primary care physician, please indicate type:

- ☐ Adult Physician (Internist, Gynecologist, Adult Specialist)
- ☐ Family Practice Physician
- ☐ General Practice Physician
- ☐ Other – Please specify:
- ☐ Pediatric Specialist
- ☐ Pediatrician

Living Situation

Where Child Currently Lives (Check only one option.)

- ☐ With Parent(s) in permanent residence
- ☐ With Parent(s) in non-permanent residence (e.g., is in homeless shelter, etc.)
- ☐ With Other Unpaid Family Member(s)
- ☐ Adult Family Home (1-2 bed)
- ☐ Alone (includes person living alone who receives in-home services)
- ☐ CBRF (1-4 bed)
- ☐ CBRF (5-8 bed)
- ☐ CBRF (more than 8 beds)
- ☐ Child Caring Institution
- ☐ Children's Group Foster Home
- ☐ Foster Care or Other Paid Caregiver's Home (e.g., 1-2 bed family home)
- ☐ Home/Apartment for which lease is held by support services provider
- ☐ ICF- MR/FDD
- ☐ DD Center/State institution for developmental disabilities
- ☐ Licensed Adult Family Home (3 bed)
- ☐ Licensed Adult Family Home (4 bed)
- ☐ Mental Health Institute/State psychiatric institution, Other IMD
- ☐ No permanent residence (e.g., is in homeless shelter, etc.)
- ☐ Nursing Home
- ☐ Treatment Foster Home
- ☐ With Live-in Paid Caregiver(s) (includes service in exchange for room & board)
- ☐ With Non-relatives/Roommates
- ☐ With Spouse/Partner
- ☐ Other (includes juvenile detention or jail) - Please specify:

If applicant is age 18 or older, record where the applicant prefers to live, irrespective of what is deemed realistic (e.g. safe, cost-effective) or what anyone else prefers. (Check only one option.)

- ☐ With Parent(s) in permanent residence
- ☐ With Other Unpaid Family Member(s)
- ☐ Alone (includes person who receives in-home services)
- ☐ With Spouse/Partner
- ☐ With Non-relatives/Roommates
- ☐ Unable to determine person's preference for living arrangement
- ☐ Other - Please specify:
- ☐ CBRF
- ☐ ICF- MR/FDD
- ☐ DD Center/State institution for developmental disabilities
- ☐ Home/Apartment for which lease is held by support services provider
- ☐ Licensed Adult Family Home (3-4 bed AFH)
- ☐ Mental Health Institute/State psychiatric institution, Other IMD
- ☐ Nursing Home
- ☐ Paid Caregiver's Home (e.g., 1-2 bed adult family home, also includes service in exchange for room & board)
- ☐ Residential Care Apartment Complex

Family/Guardian's Preference for where applicant lives (Check only one option.)

- ☐ With Parent(s) in permanent residence
- ☐ With Other Unpaid Family Member(s)
- ☐ Alone (includes person who receives in-home services)
- ☐ With Spouse/Partner
- ☐ With Non-relatives/Roommates
- ☐ Unable to determine person's preference for living arrangement
- ☐ Other - Please specify:
- ☐ CBRF
- ☐ ICF- MR/FDD
- ☐ DD Center/State institution for developmental disabilities
- ☐ Home/Apartment for which lease is held by support services provider
- ☐ Licensed Adult Family Home (3-4 bed AFH)
- ☐ Mental Health Institute/State psychiatric institution, Other IMD
- ☐ Nursing Home
- ☐ Paid Caregiver's Home (e.g., 1-2 bed adult family home, also includes service in exchange for room & board)
- ☐ Residential Care Apartment Complex

For people 18 years and older who are not living with a parent or other family member, does the person: (Check only one option.)

- ☐ Own the home
- ☐ Hold the lease
- ☐ Hold a co-Signed lease and have control over the physical environment
- ☐ Work with an agency that holds the lease, but has control of the setting, and the right to hire and fire providers
- ☐ Have a signed agreement or Individual Service Plan with the agency or provider giving control of the setting to the person
- ☐ Have a provider who as a condition of provider certification has given control of the setting to the person.

If the child is not currently living at home, is there a plan to return to home within 6 months of screening date?

- ☐ N/A
- ☐ Yes
- ☐ No

Diagnoses

Response for "Diagnoses" and "Transplant Information" is based upon: (Choose one option for each question.)

Parent Report	**Allowable Documentation (copy provided)**
☐ Yes	☐ Yes
☐ No	☐ No

Has the child been determined disabled by social security administration?

- ☐ Yes
- ☐ No
- ☐ Don't Know

Transplanted Organ	Pending	Had On (mm/yyyy)
☐ Bone Marrow	☐	/
☐ Heart	☐	/
☐ Intestine	☐	/
☐ Kidney	☐	/
☐ Liver	☐	/
☐ Lung	☐	/
☐ Pancreas	☐	/

Check all diagnoses that apply.

- ❑ Allergies
- ❑ Anemia, (e.g., Sickle Cell, Fanconi's)
- ❑ Anorexia Nervosa-307.1, Bulimia and other Eating Disorders-307.51, 307.52, 307.53, 307.59
- ❑ Antisocial Personality Disorder-301.7, 301.81, 301.82
- ❑ Anxiety Disorders- 293.89, 300.00, 300.21, 300.22, 300.23, 300.29, 300.7, 300.01, 300.02, 300.16, 300.19
- ❑ Arthritis
- ❑ Asperger's Syndrome –299.80
- ❑ Asthma
- ❑ Attention-Deficit Disorder and Disruptive Behavior Disorders 314.00, 314.01, 314.9
- ❑ Autism or Autism Spectrum –299.00, 299.10 (Only codes)
- ❑ Bi-Polar Disorder 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 297.7, 296.80, 296.89
- ❑ Blind ("legally") = uncorrectable 20/200
- ❑ Brain Disorders (other than seizures) or Brain Damage
- ❑ Brain Injury—Traumatic (per statutory definition of TBI)
- ❑ Cancer-- not Leukemia
- ❑ Cardiac conditions
- ❑ Cerebral Palsy
- ❑ Cerebral Vascular Accident (CVA) (pre- or postnatal)
- ❑ Conduct Disorder- 312.8, 312.9, 313.23
- ❑ Congenital Abnormalities
- ❑ Contractures/ Connective Tissue Disorders
- ❑ Cystic Fibrosis
- ❑ Deaf or severely hearing impaired
- ❑ Dehydration/ fluid & electrolyte imbalances
- ❑ Depersonalization Disorder 300.6
- ❑ Depression 296.20, 206.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36.
- ❑ Developmental Delay
- ❑ Developmental Disability
- ❑ Digestive System disorders (of mouth, esophagus, stomach, intestines, gall bladder, pancreas)
- ❑ Dissociative Disorders 300.12, 300.13, 300.14, 300.15
- ❑ Down Syndrome
- ❑ Endocrine Disorder (not diabetes)
- ❑ Failure to Thrive
- ❑ Fetal Alcohol Syndrome/ Effects
- ❑ Genetic / Chromosomal Disorders
- ❑ Genitourinary system disorders
- ❑ Hemophilia/ Other blood disorders
- ❑ Hypochondriasis and Body Dysmorphic Disorder 300.7
- ❑ Immune Deficiency
- ❑ Impulse-Control Disorders 312.30, 312.33, 312.34
- ❑ Infections--Current or recurrent infections
- ❑ Leukemia
- ❑ Mental Retardation
- ❑ Mood Disorders and Dysthymic Disorder-300.4, 293.83, 296.90
- ❑ Metabolic Disorders
- ❑ Multiple Sclerosis or ALS
- ❑ Muscular Dystrophy
- ❑ Nutritional Imbalances (e.g, malnutrition, vitamin deficiencies)?
- ❑ Obsessive-Compulsive Disorder 300.3
- ❑ Oppositional Defiant Disorder-313.81, 313.89
- ❑ Other Disorders of Infancy. Childhood or Adolescence 307.3, 309.21, 313.89
- ❑ Paralysis Other than Spinal Cord Injury
- ❑ Paralysis—Spinal Cord Injury
- ❑ Personality Disorders 301.0, 301.20 -, 301.22, 301.4, 301.50, 301.6, 301.7, 301.81, 301.82, 301.83, 301.9
- ❑ Pervasive Developmental Disorder –299.00, 299.80 Childhood Disintegrative Disorder 299.10
- ❑ Post-Traumatic Stress or Acute Stress Disorder 309.81,308.3
- ❑ Prader-Willi Syndrome
- ❑ Prematurity / Low Birth Weight
- ❑ Renal Failure or other Kidney Disease
- ❑ Respiratory condition (other than asthma)
- ❑ Rett's Syndrome – 299.80
- ❑ Schizophrenia and Other Psychotic Disorders 293.81, 293.82, 295.10 , 295.20, 295.30, 295.40, 295.60, 295.70, 295.90, 297.1, 297.3, 298.9
- ❑ Scoliosis, Kyphosis
- ❑ Seizure Disorder
- ❑ Sensory Disorders (other than blind or deaf)
- ❑ Sexual and Gender Identity Disorders 302.2, 302.3, 302.4, 302.5, 302.6, 302.85, 302.89, 302.9
- ❑ Skin Disease
- ❑ Somatoform Disorders 300.11, 300.81
- ❑ Spina Bifida
- ❑ Stereotypic Movement Disorder 307.3
- ❑ Substance-Related Disorders, inc. Alcohol Abuse- (not to include caffeine or nicotine addictions) 303.90, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 304.90, 305.00, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90
- ❑ Terminal Illness (prognosis < 6 months)
- ❑ Tic Disorders 307.20, 307.22, 307.23
- ❑ Tourette's syndrome 307.23
- ❑ Tuberous Sclerosis
- ❑ Wound, Burn, Bedsore, Pressure Ulcer
- ❑ Other. Please specify:

Mental Health

Does child have an emotional disability that has persisted for at least 6 months and is expected to persist for a year or longer?
☐ Yes
☐ No

If yes to 'emotional disability' question above: Does child have any of the following symptoms? (Check all that apply.)
☐ Psychosis — Serious mental illness with delusions, hallucinations, and/or lost contact with reality
☐ Suicidally — Suicide attempt in past 3 months or significant suicidal ideation or plan in past month
☐ Violence — Violent behavior to others, or destruction of property including fire-setting
☐ Anorexia / Bulimia — Weight loss of at least 25% of original body weight with resultant electrolyte imbalance or cardiac dysfunction

If yes to 'emotional disability' question above: Does child currently require services from any of the following? (Check all that apply.)
☐ Mental Health Services
☐ Child Protective Services
☐ Juvenile Justice system
☐ In-school Supports for Emotional and/or Behavioral Problems
☐ Substance Abuse Services

If child currently receives any of the above services, are supports more than 3 hours/week combined?
☐ Yes
☐ No

Behaviors

Is child currently an adjudicated delinquent?
☐ Yes
☐ No

Check all that apply.	
☐	**Lack of behavioral controls:** Lacks appropriate behavioral controls such that child can not be at home or in community settings without causing disruptions or distress to others: ☐ Requires interventions weekly on average, or less often. ☐ Requires interventions more than once within a week.
☐	**High-Risk Behaviors:** Consistent lack of age-appropriate decision-making, judgment and value systems. May include risky behaviors such as unsafe social or sexual behaviors, substance abuse, running away, walking into traffic, unable to identify people or situations that are threatening. ☐ Child is unable to understand risks. ☐ Child is cognitively able to understand but still engages in high-risk behaviors.
☐	**Self Injurious Behaviors** (e.g., head-banging, self-mutilation, polydipsia, pica)
☐	**Violent or offensive behavior toward others:** includes violence; destruction of property including fire-setting; or behaviors such as spitting, masturbating or disrobing in public. Also includes sexually inappropriate behavior towards children or adults.
☐	**Relationships:** Consistent inability to form and sustain friendships and to perform age-appropriate social roles (e.g., neighbor, peer, family member).
☐	**School and/or Work:** ☐ Failing grades, repeated truancy and/or expulsion; suspension; and/or inability to conform to school or work schedule and expectations. ☐ Child meets the definition of "a child with a disability" who needs special education as defined under § 115.76 of Wisconsin State Statute.

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Please refer to separate document containing age-specific ADL and IADL questions.

Child currently has substantial functional impairments in ADL or IADL that are expected to last for at least 1 year from date of screening:

- ☐ Yes
- ☐ No

Child does NOT have impairments now, but has a verified diagnosis that is expected within one year to cause substantial functional impairments in: (Check all that apply.)

- ☐ Self-care
- ☐ Mobility
- ☐ Learning and Play
- ☐ Communication

Work and School

Is child currently attending high school?

- ☐ Yes
- ☐ No

What year is the child expected to leave school?

Year (yyyy):

Expected Supports After Leaving School (check all that apply)

- ☐ None
- ☐ Not known at this time
- ☐ Benefit Specialist
- ☐ Division of Vocational Rehabilitation (DVR)
- ☐ Other – Please specify:
- ☐ Section 504 Plan
- ☐ Transition Individual Education Plan (IEP)
- ☐ Transition Services from the County

Does the child's health or stamina level cause child to miss over 50% of school or classes or to require home education?

- ☐ Yes
- ☐ No

Current Employment Status

- ☐ Not employed
- ☐ Employed full time
- ☐ Employed part-time

Employment Interest

- ☐ Interested in new job
- ☐ Not interested in new job

If Employed, Where

- ☐ Attends pre-vocational day/work activity program
- ☐ Attends sheltered workshop
- ☐ Has paid job in the community
- ☐ Works at home

Need for Assistance to Work (optional for unemployed persons)

- ☐ Independent (with assistive devices if uses them)
- ☐ Needs help weekly or less (e.g., if problems arise)
- ☐ Needs help every day but does not need the continuous presence of another person
- ☐ Needs the continuous presence of another person

Health Related Services

Medical or Skilled Nursing Needs (Check all that apply.)

- ☐ Rehabilitation program for brain injury or coma—minimum 15 hours/week
- ☐ Positioning every 2 hours (unable to turn self)
- ☐ Terminal condition (prognosis < 12 months)
- ☐ Tracheostomy
- ☐ Ventilator (positive pressure)
- ☐ PT, OT, or ST by therapist (does not include behavioral therapies)
  - ☐ Up to 5 sessions/ week
  - ☐ 6 or more sessions/week
- ☐ PT, OT, ST therapy follow-through: Exercises, sensory stim, stander, serial splinting/casting, braces, orthotics
  - ☐ Less than 1 hour/day
  - ☐ More than 1 hour/day
- ☐ Wound or special skin care
  - ☐ Less than 1 hour/day
  - ☐ More than 1 hour/day

Place one check-mark per any row that applies.

		FREQUENCY AT WHICH CHILD NEEDS "SKILLED NURSING" HELP FROM OTHERS			
HEALTH-RELATED SERVICES	**Indepen-dent with task**	**1 to 3 times/ Month**	**1 to 3 times/ Week**	**4 to 7 times/ week**	**2 or more times a day**
Person has life-threatening incidents with sudden on-set.					
BOWEL- or OSTOMY-related SKILLED Tasks (digital stim, ostomy site care, changing wafer, irrigation)					
DIALYSIS (hemodialysis or peritoneal, in home or at clinic)	**N/A**	**N/A**			
IVs -- peripheral or central lines --- fluids, medications, TPN, transfusions. Does not include site care.					
OXYGEN &/or deep SUCTIONING --With Oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.					
RESPIRATORY TREATMENTS: Chest PT, C-PAP, Bi-PAP, IPPB treatments (does NOT include inhalers or nebulizers)					
TPN (Total Parenteral Nutrition) Does not include site care.					
TUBE FEEDINGS Does not include site care.					
URINARY CATHETER-RELATED SKILLED TASKS (straight caths, irrigations, instilling meds) Does not include site care.					

How long have the skilled nursing needs and health related services selected above ALREADY lasted? (Check only one option.)
☐ Less than 6 months
☐ 6 months to 12 months
☐ 12 months or more

How long are the skilled nursing needs and health related services selected above EXPECTED to last? (Check only one option.)
☐ Less than 6 months
☐ 6 to 12 months from now
☐ More than 12 months from now

Developmental Information

Does the child have any of the following? (Check all that apply.)
☐ Diagnosis of MENTAL RETARDATION
☐ Full-scale (FS) IQ of less than 75, with cognitive impairment NOT due to mental illness or substance abuse
☐ Another condition similar to mental retardation EXCLUDING: Dementia/ Senility, Behavioral diagnoses, Mental Illness, Learning disability, Attention deficit/ ADHD, Substance Abuse, Emotional disturbances, Hyperactivity

This condition noted above, and not any other condition, requires ON-GOING SUPPORT (planning, supervising, monitoring, cueing, or hands-on help) that is (Check all that apply):
☐ Of extended duration
☐ Individually planned and coordinated
☐ To address social, intellectual and behavioral deficits
☐ In order to develop self-direction and independence and/or to prevent loss of optimal functional status

Risk

Risk Evident During Screening Process (Check all that apply.)	
☐ No risk factors or evidence of abuse or neglect apparent at this time.	
Parents/caregivers' situation is at risk due to (check all that apply):	
	☐ Difficulties in meeting the child's complex medical or health needs ☐ Difficulties in meeting the child's complex behavioral or mental health needs ☐ Parent's medical or health needs ☐ Parent's mental needs ☐ Parent's substance abuse needs ☐ Domestic violence issues ☐ Involvement with the criminal justice system
Exacerbation (check all that apply):	
	☐ Child's medical symptoms within last 12 months ☐ Child's behavioral or mental health symptoms within last 12 months
Other Concerns (check all that apply):	
	☐ Behaviors place the child at risk of removal from home (or equivalent residence).
	☐ The child has had a significant increase in the need for assistance in ADLs, IADLs, and/or health-related services over the last 3 months.

	☐ There are statements of, or evidence of, possible abuse, neglect, self-neglect, or financial exploitation.	
	If yes: ☐ Referring to CPS now ☐ Referring to APS now ☐ Competent adult refuses to allow referral to APS	
	Comments:	
	☐ The child's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months).	

Screen Completion Time

Screen Completion Date (mm/dd/yyyy):
/ /

Time to Complete Screen	Hours	Minutes
Face-to-Face contact with the child and parent(s) or guardian This can include an in-person interview, or observation if child cannot participate in interview.		
Collateral Contacts Either in-person or indirect contact with any other people, including other family members, advocates, providers, etc.		
Paper Work Includes review of medical documents, COP assessment, etc		
Travel Time		
Total Time to Complete Screen		

TRANSFER INFORMATION

To be completed after eligibility determination and enrollment counseling, and after applicant enrolls in a program.

Referral date to service agency (mm/dd/yyyy):____/____/____ Service Agency: _____